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ABSTRACT

The second in a series, this volume highlights 18 indicators of children's well-being in the 50 states and presents case studies of 5 states' strategies to prevent various problems among the birth to 5-year-old population. Indicators are grouped according to factors that may place young children at risk; these include: (1) mandatory kindergarten attendance; (2) poverty; (3) health status; (4) age, welfare, and employment status of mothers; (5) participation in state and federal support programs; and (6) indicators of long-term dependency. Statistical tables provide information for each indicator by national region/state. Case studies concern Illinois' Ounce of Prevention Fund, Maine's children's deaths initiative (the "Governor's Agenda for Children"), Missouri's Parents as Teachers Program, New Jersey's HealthStart initiative, and South Carolina's Interagency Early Childhood Development and Education Council. The case studies, which are based on interviews with key respondents, provide a record of how the states identified problems, developed a programmatic response, built public support, generated interagency cooperation, garnered cooperation from the business community, secured legislative approval and funding, implemented and monitored programs, and conducted evaluations. The case studies offer a generic blueprint and strategic lessons for other states seeking to implement primary prevention programs. Additional indicators for which states should collect data are identified. (RH)

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The First Sixty Months

The Next Steps

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

November 1987

Dear Governor:

The first sixty months are the most critical in a person's life, yet they often are the forgotten months when significant social, health, and educational problems take root. Problems not identified nor addressed during this stage become far more difficult to completely and permanently correct with the approach of adolescence and adulthood. For this reason, we need to change the focus of our present human services systems which tend to treat the symptoms of problems, rather than their causes.

Focus on the First Sixty Months: The Next Steps represents the second publication to emerge from an early childhood project undertaken at my request by the Council of State Governments (CSG) and the National Governors' Association (NGA). In July 1987, the "Focus" project at NGA released *A Handbook of Promising Prevention Programs for Children Zero to Five Years of Age*. That handbook described nineteen exemplary state programs providing prevention services to young children.

The Next Steps, a collaboration between NGA and CSG, represents a logical companion to the earlier handbook, and is a guide to implementation strategies for early childhood prevention programs. The guide identifies indicators of children's well-being in the states. These proxies serve as a reference point for determining which problems need to be addressed, and provide states with a tool to track the progress of their prevention programs. The handbook concludes with case studies on *how* five states moved from identification of a problem to implementation and assessment of a program.

Let us focus on prevention and early intervention of potential problems in our youngest citizens, by involving parents and other caregivers in close contact with young children. We have the opportunity to treat the causes, to make good on our promise of success for the next generation, and to remove any barriers to self-sufficiency and productivity. I commend this guide to you as you undertake the effort.

Sincerely,

Michael N. Castle

Michael N. Castle
Governor of Delaware
Chairman
NGA Committee on Human Resources
and
Former Chairman
CSG Committee on Intergovernmental Affairs

Focus On

The First Sixty Months: The Next Steps

A Guide to Implementation

A Joint Product of the National Governors' Association
Committee on Human Resources
and
Center for Policy Research
and
The Council of State Governments

Acknowledgements

A number of individuals devoted time and energy to the effort which resulted in this handbook. Barbara Blum, President, and Susan Blank and Jane Dustan of the Foundation for Child Development, are gratefully acknowledged for their advice, assistance, and financial support to the project.

Special appreciation is extended to the individuals who responded to in-depth interviews for the case studies. They include: for Illinois, Irving Harris, President, The Pittway Corporation and Greg Coler, former Director, Department of Public Aid and Department of Children and Family Services; for Maine, Michael Petit, former Commissioner, Department of Human Services; for Missouri, Mildred Winter, Director, Parents as Teachers' National Center; for New Jersey, Molly Coy, Commissioner, Department of Health and Susan Goldman, Director, HealthStart; and for South Carolina, Terry Peterson, former Executive Assistant to the Governor for Education.

The National Governors' Association's (NGA) Center for Policy Research staff who researched and developed the handbook include Charles Brackney and Lynne Fender. Editorial support was provided by Karen Glass and production support by Francine Matthews. Stacey Crane, of the Council of State Governments (CSG), assisted with the research and development. Joan Wills of NGA and Norman Beckman of CSG supervised the writing of this document.

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OVERVIEW

During Delaware Governor Michael N. Castle's first term as Chairman of NGA's Human Resources Committee, he chose to make a "Focus on the First Sixty Months," a priority of the Committee and of his state's human service delivery system. In January 1986, he wrote in an article for the *Governors' Weekly Bulletin:*

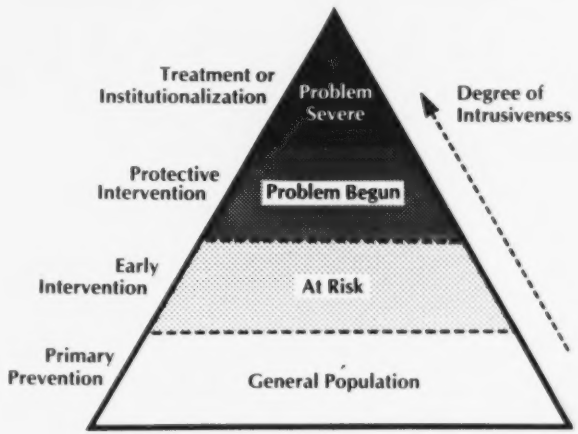
> Children who grow up in poor health, in broken homes, in poverty or without education are more likely to be illiterate and unemployed adults. Further, we are realizing that many problems actually start during the earliest stages of life.

In his role as Chairman of the Council of State Governments' Intergovernmental Affairs Committee, Governor Castle chaired a series of regional hearings which CSG and NGA convened on successful prevention and early intervention programs for young children. At each of these hearings, the oversight committee heard testimony on intergovernmental/ interagency programs designed to prevent problems from occurring in early childhood. The purpose of those hearings was to provide state elected officials further insight as to how they could give priority to and fund prevention programs, and incorporate them into their own early childhood service delivery systems.

In February 1986, the NGA committee held a national conference, featuring presentations by individuals from public and private institutions at the state and local levels. The speakers described successful programs aimed at preventing health, education, and social problems among children zero to five years of age. During his closing conference address, Governor Castle called on NGA to develop a handbook of prevention initiatives and an implementation strategies handbook, "so that we can present to the Governors of the states a . . . package of ideas that are cost effective, that represent a coordinated approach to childhood issues, and that work . . ."

The first handbook, published in July 1987, documented the vital need for more focus on primary prevention programs for this nation's youngest children. It cited national data on some of the deficits faced by children aged zero to five, and the expensive, intensive interventions later required if they are not treated. Discussed in the publication are the effectiveness and affordability of prevention and the rationale behind the continuing reliance on intensive treatment.

As a tool to help refocus thinking and redirect resources toward prevention programs, the handbook's overview section includes a graphically presented working definition of prevention. A continuum of prevention/ intervention is shown in the form of a triangle:



Movement from the base of the triangle, the general population, to its apex, severe problems, is shown to involve smaller and smaller groups in the populace but ever increasing degrees of intrusion into person's lives. As problems become more severe, intervention strategies also become more costly and less effective.

Finally, the first volume includes a description of nineteen diverse prevention programs, selected to suggest the flavor, diversity, and patterns of success that other states may wish to adopt. Among the patterns of success drawn from them are that they:

- reach out to multiple agencies, whether public or private, in order to deliver an array of needed services;
- often go into families' homes, rather than expecting participants to report to agency offices;
- target multiple problems, albeit a single problem is the initial focus;
- mix funds from public and private, state and local sources;
- include some evaluation effort, to measure the extent of the program's impact and learn whether or not the delivery model needs refinement;
- maximize parent involvement so parents ultimately can be the service providers and advocates for their children; and
- focus on the lowest two rungs of the prevention triangle—the general and at-risk populations—where the greatest benefit is likely to be achieved for the least cost and with the least intrusion.

This second volume, *Focus on the First Sixty Months: The Next Steps,* highlights eighteen indicators of children's well-being in the states, permitting a comparison among the states in each of nine regions. Analysis of these indicators permits states to select one or more areas in which improvement is needed and focus attention and resources on a prevention strategy in those areas. For example, if the indicators reveal that a state has a comparatively high low-birthweight rate and mortality rate among its infants, relative to its regional neighbors, this state might choose to design and implement an aggressive prenatal care program for at-risk, pregnant women. In this instance, the highly successful Mississippi model, described in the earlier *Handbook of Promising Prevention Programs for Children Zero to Five Years of Age,* might be one to look to for replication. Similarly, if a state has a comparatively high high school dropout rate—a predictor of high youth unemployment, teenage births, and welfare dependency—it might choose to implement an early childhood development program for at-risk preschool children. In this instance, the state could look to Arkansas, Missouri, and South Carolina for examples of "parents as teachers" programs and early child development programs for four-year-olds. Numerous additional connections can be made by states, analyzing the indicators of children's well-being presented in this guide and selecting an appropriate prevention program from the first volume.

Case studies of five states' strategies to prevent one or more problems among their zero-to-five-year-old population, comprise the remainder of the guide. Based on interviews with key respondents, they provide an oral record of how these states:

- identified the problem;
- developed a programmatic response;
- built public support;
- generated interagency cooperation;
- garnered cooperation from the business community;
- secured legislative approval and funding;
- implemented and monitored the program; and
- conducted an evaluation.

Taken together, these case studies offer a generic blueprint and strategic lessons for other states seeking to implement primary prevention programs for their youngest citizens.

Governor Castle encourages all in this generation to take responsibility for those who will follow, for "our children are the world's greatest resource and our greatest hope for the future. Their ability to build a better future will depend upon the foundation we lay for them." It is hoped the two volumes of Focus on the First Sixty Months will challenge and guide states as they strive to lay that foundation.

"For children, the challenge is to prevent the cycle of dependency from claiming another generation."

–Governor Michael N. Castle

INTRODUCING THE INDICATORS

One of the reasons that approaches to address the ills of children typically focus on treatment rather than prevention is that the immediate problem is more readily identifiable. Another is that the result of the action is much more easily observed and quantified. As an illustration, a program which removes abused children from their bad environments can point to the number of children placed in foster homes where presumably they are distanced from the threat of further abuse.

The results of prevention, however, are less easily identified. It is very difficult to measure the number of children saved from child abuse and subsequent out-of-home placement as a result of children and their families participating in parenting and child development training. Moreover, the results of prevention programs usually take a relatively long time to become apparent.

An Advisory Committee of social service professionals and analysts recommended to NGA staff a substantial list of indicators of children's well-being for inclusion in this guide. The proxies presented in the tables that follow are distilled from that list, and reflect the more limited set of indicators for which reliable state-level data currently are available. More is needed. State policy makers are challenged to collect and synthesize data on additional indicators so they can monitor the status of children in their state. A number of states in the past two or three years have recognized this challenge. They assembled and disseminated to policy makers and legislators over 100 indicators on children, designed to provide a foundation from which prevention policy and programs could be built and progress tracked. Other states are urged to follow this lead.

The indicators presented in this guide represent a composite of different kinds of information. A few merely provide a contextual base from which to view other indicators, e.g., percent of a state's population under age five or, similarly, under age eighteen. Some offer a glimpse into the current status of states' youngest children such as low-birthweight rate or percent of children under age five living in poverty. Still others present indices of the "cost" of inattention to prevention, e.g., number of mothers under age 20 receiving AFDC benefits, the percent of youth unemployed, or number of juveniles in custody per 100,000 juveniles in the population. Collectively, they offer a short-term and a long-term perspective on where prevention strategies should be focused and where the unintended consequences fall if those strategies are not focused.

One gripping illustration of the links to be drawn between this mix of indicators will help convey the implications for prevention. Nationally, it is estimated that 80 percent of today's prison population were abused as children. If those data were available on a state-by-state basis (which they are not), and a state could see that it had a relatively high rate of child abuse and a high rate of juveniles in custody, it could readily determine that preventing child abuse in the early years of children's lives could reduce the incidence of juveniles in custody and, ultimately, the costly business of maintaining adults in prison.

The next section of the guide lists and explains the indicators for which state data are available. Also suggested is a minimum set of additional indicators that states might want to consider collecting.

Below are definitions of the proxies for children's well-being referenced in the handbook. They are grouped according to factors or circumstances which may place young children at risk. The descriptions are followed by a map and tables presenting state data on the indicators. In addition, two charts illustrate selected information from the tables. The first compares state infant mortality rates to the goal for 1990 set by the U.S. Surgeon General. The second compares the percent of children under age five in the states' populations to the percent of these children living in poverty.

Mandatory Kindergarten Attendance

- *The Governors' 1991 Report on Education: Time for Results* calls on states to make kindergarten attendance mandatory, as a means to promote readiness for school, especially among at-risk children.

Children in Poverty

- **Percent of population under age 5.** This group represents the poorest segment of today's society and the one most amenable to prevention programs.
- **Percent of population under age 5 living in poverty.** One in four of these children is growing up in poverty.
- **Percent of population under age 18.** Children under age 18 are 70 percent more likely than adults to be living in poverty.
- **Percent of population under age 18 receiving Aid to Families with Dependent Children (AFDC).** These data can be highly correlated with the state's standard of need. Thus, in a state with a high standard of need, the figures may indicate that more people are eligible for and receiving public assistance than in a state with a low standard of need.

Infant Health

- **Infant mortality rate.** This statistic represents the number of children who die in their first year, per 1,000 live births. Especially disconcerting, the United States' rate for black children is 18.2 per 1,000. The Surgeon General has set an overall goal of 9.0 per 1,000 by 1990.
- **Percent of low-birthweight infants.** Low birthweight, the most important determining factor in infant deaths, is defined as a birthweight at or below five and one-half pounds, or 2,500 grams.
- **Percent of women not receiving prenatal care in first trimester.** Late or no prenatal care is a strong predictor of low birthweight and other birth complications.

Young Mothers and Young Children

- **Number of births to mothers under age 20.** A teenage mother is more likely than an older woman to bear a low-birthweight baby or an infant with a disability. Just under 14 percent of all births in the United States are to mothers under age 20, the highest rate among all other Western developed nations.
- **Number of mothers under age 20 receiving AFDC benefits.** More than half of all AFDC expenditures go to support families in which the mother was a teenager at the time of her first birth (and often the second and third births).
- **Percent of working mothers with children under age 6.** These mothers and their children are behind the upsurge in the demand for child care. Even more compelling is that more than half of all mothers with children under age three are in the workforce. This percentage has tripled since 1960, and the labor market participation of mothers with the youngest children is increasing the fastest.

State and Federal Support Programs

- **Combined AFDC and Food Stamp benefits as a percent of the poverty level.** AFDC benefits vary sharply from state to state. The lower the AFDC benefit in a state, the higher, commensurately, is the Food Stamp benefit.
- **Percent of WIC financially eligible population actually served.** The federal Supplemental Food Program for Women, Infants, and Children (WIC) provides food assistance and nutritional screening services to low-income pregnant and parenting women and to children up to age five. However, the program does not serve all those who are eligible; in fact, over 100 counties have no WIC program. Nationally, less than half of those eligible for benefits receive them. The program has been found to have a major impact on the reduction of low-birthweight infants nationwide.
- **Percent of cases in which a collection on a child support obligation was made.** These figures refer to the cases now in the states' child support system. Nationwide, less than half (45.8 percent) of all support money owed was collected in 1986.

Indicators of Long-Term Dependency

- **High school dropout rate.** This statistic reflects the percent of an enrolled freshman class which did not graduate four years later. The earnings gap between high school graduates and dropouts had grown to 59 percent by the early 1980s.
- **Percent of youth ages 16 to 19 unemployed.** This rate correlates to the high school dropout rate. Moreover, a recent study has shown the teenage unemployment rate to be a cause in the high rate of unwed teenage parents. This is because teen mothers do not marry young, unemployed fathers.
- **Number of juveniles in custody per 100,000 juveniles in the population.** There were 49,322 juveniles in public custodial facilities in 1985, at an annual cost of over $16,000 per youth.
- **Percent of total population receiving public assistance.** This figure includes both adults and children receiving AFDC or federal Supplemental Security Income assistance. The information takes on added significance when juxtaposed with data presented earlier on the percent of those under age 18 receiving AFDC.

Additional data were desired for the tables, but research proved them unobtainable on a state-by-state basis. The following are suggested as the minimum additional indicators for which states should collect data. Together with those presented in the following tables, they would allow states a more complete picture of their at-risk young children and an opportunity for a more complete tracking of prevention programs.

- **Children's deaths.** This would include tracking the rate of children's deaths and the causes of these deaths. The major causes of children's deaths are diseases and illnesses, accidents, suicide, and homocide. In 1980, the nation's rate for children's deaths was 110.4 per 100,000.

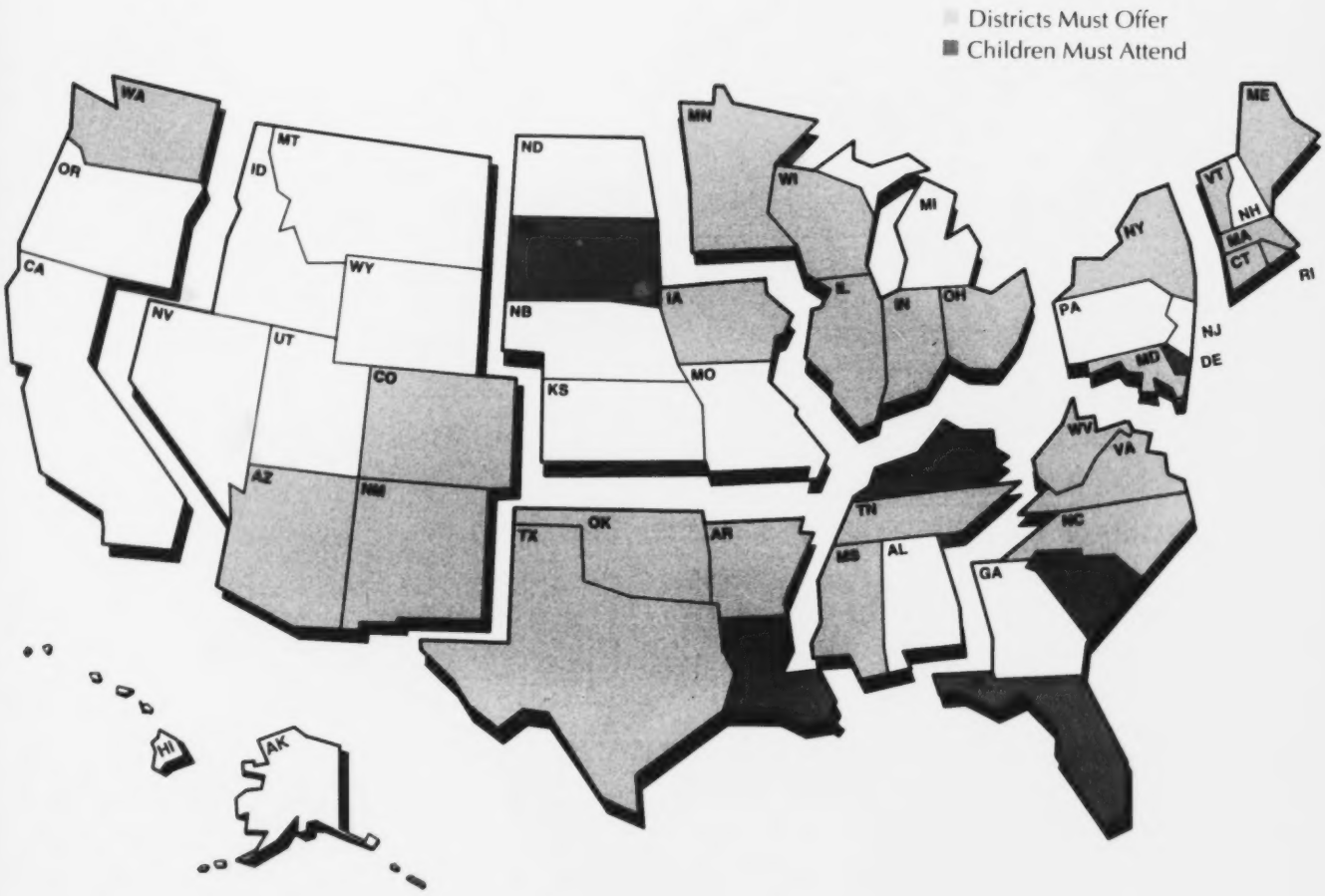
- **Preschooler immunization.** Thirty percent of all children ages one to four have no immunization against the major childhood diseases. The percentage of children immunized against measles, diptheria, and polio actually has decreased in the last ten years.
- **Demand for child care.** This figure could be compared with information on the actual number of child care slots available in a state to show the problematic lack of quality, affordable child care.
- **Children repeating first grade.** A high number in this category would indicate a widespread lack of readiness for school among children and could serve to focus attention on preschool programs for children and their parents.
- **Number of victims of child abuse.** The statistics currently collected on a nationwide basis suffer from two problems. First, the data usually are based on reports of abuse rather than substantiated cases. Second, the standards for data reporting and collection vary from state to state, making such comparisons less meaningful than, for example, infant mortality rates. A more reliable measure to suggest the magnitude of this problem is needed. Approximately thirty states currently report the incidence of substantiated cases to the American Humane Society in an annual survey. National estimates are derived from this survey.

INDICATORS

"Indisputably, research indicates that children who have had kindergarten experience perform better in the first grade than those who have not. This is a first and basic step toward providing readiness experiences so necessary for at-risk children."

–Time for Results: The Governors' 1991 Report on Education

MANDATORY KINDERGARTEN ATTENDANCE



Source: Education Commission of the States 1987

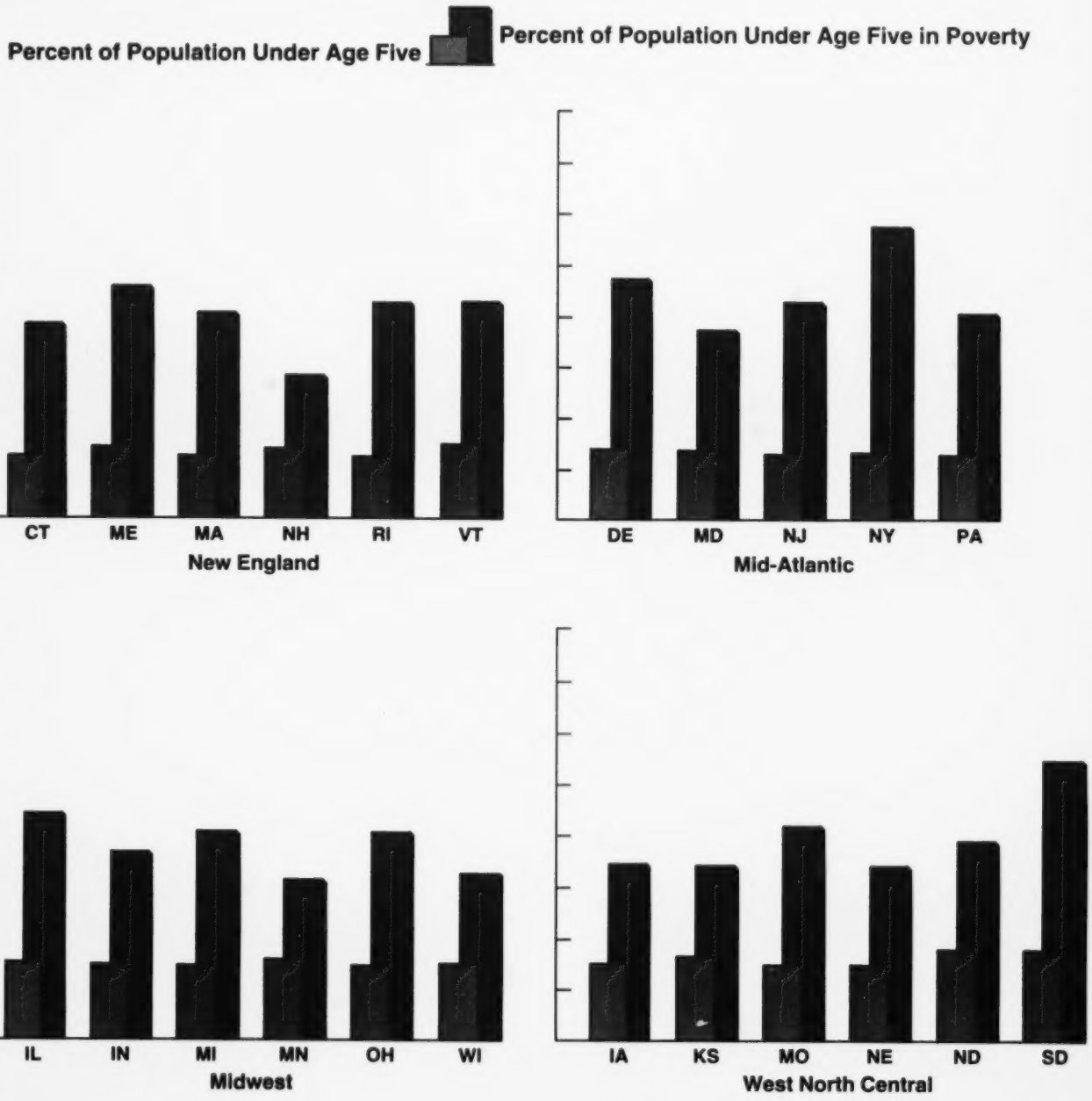
CHILDREN IN POVERTY

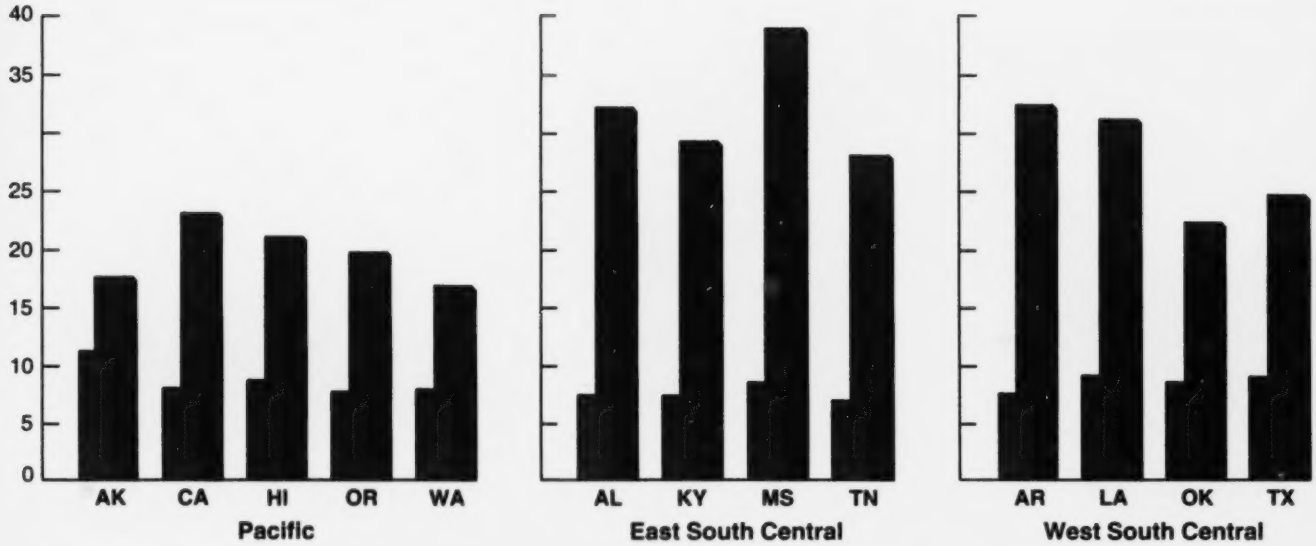
Region	State	Percent of Population Under Age 5 1984	Percent of Population Under Age 5 Living in Poverty 1985	Percent of Population Under Age 18 1984	Percent of Population Under Age 18 Receiving AFDC 1984
Total United States		**7.5**	**25.0**	**26.5**	**11.3**
New England	Connecticut	6.2	19.1	23.7	10.9
	Maine	7.1	22.8	26.5	10.5
	Massachusetts	6.2	20.2	23.5	11.2
	New Hampshire	7.0	14.2	25.8	4.0
	Rhode Island	6.2	21.3	23.5	12.4
	Vermont	7.4	21.4	26.4	9.9
Mid-Atlantic	Delaware	7.0	23.6	25.3	10.7
	Maryland	6.9	18.6	24.9	11.4
	New Jersey	6.5	21.3	24.7	13.3
	New York	6.7	28.8	24.7	16.6
	Pennsylvania	6.5	20.2	24.5	12.9
Midwest	Illinois	7.7	22.0	26.5	15.9
	Indiana	7.4	18.4	27.5	7.3
	Michigan	7.3	20.4	27.4	18.3
	Minnesota	7.9	15.7	27.0	7.9
	Ohio	7.3	20.4	26.8	14.6
	Wisconsin	7.5	16.2	26.8	13.5
West North Central	Iowa	7.6	17.2	26.9	9.7
	Kansas	8.2	17.1	26.7	6.8
	Missouri	7.5	20.9	26.2	9.6
	Nebraska	8.2	17.1	27.6	6.2
	North Dakota	8.9	19.4	28.9	3.8
	South Dakota	8.9	27.3	29.2	5.5
East South Central	Alabama	7.4	32.0	27.8	9.4
	Kentucky	7.4	29.2	27.7	10.1
	Mississippi	8.5	38.9	30.7	14.1
	Tennessee	7.0	27.9	26.4	8.3
South Atlantic	Florida	6.6	27.1	22.9	7.6
	Georgia	7.6	29.1	28.0	10.1
	North Carolina	6.7	25.1	26.0	6.9
	South Carolina	7.6	28.2	28.1	9.1
	Virginia	6.9	21.1	25.3	7.3
	West Virginia	7.0	24.5	27.2	11.7

CHILDREN IN POVERTY (Cont'd)

Region	State	Percent of Population Under Age 5 1984	Percent of Population Under Age 5 Living in Poverty 1985	Percent of Population Under Age 18 1984	Percent of Population Under Age 18 Receiving AFDC 1984
Total United States		**7.5**	**25.0**	**26.5**	**11.3**
West South Central	Arkansas	7.5	32.2	27.8	6.8
	Louisiana	9.1	31.1	30.4	11.5
	Oklahoma	8.5	22.2	27.9	6.0
	Texas	9.0	24.6	29.5	5.0
Mountain	Arizona	8.5	23.4	28.1	5.9
	Colorado	8.3	17.4	26.9	6.4
	Idaho	9.6	20.8	32.2	3.6
	Montana	8.5	21.2	28.6	5.7
	Nevada	7.7	14.7	25.7	3.8
	New Mexico	9.3	29.7	30.6	7.8
	Utah	12.5	16.0	37.8	4.0
	Wyoming	10.2	10.3	31.3	3.6
Pacific	Alaska	11.2	17.6	32.4	6.2
	California	8.1	23.0	26.0	15.5
	Hawaii	8.7	20.9	27.6	11.8
	Oregon	7.7	19.7	26.5	6.6
	Washington	7.9	18.8	26.6	8.9

Poverty in the First Sixty Months

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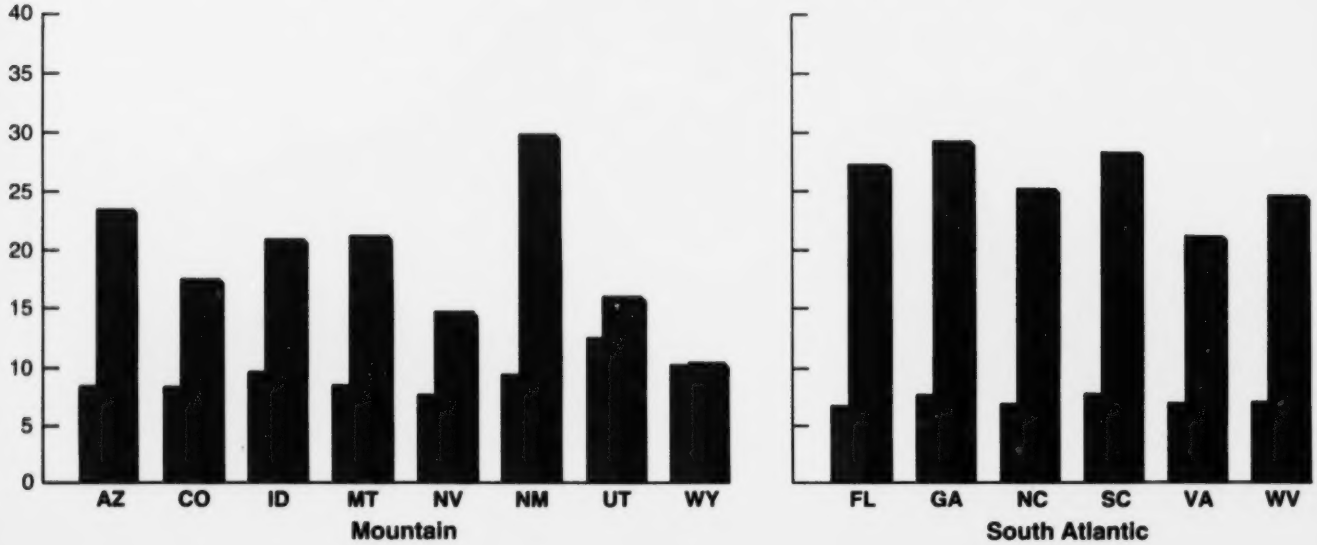
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INFANT HEALTH

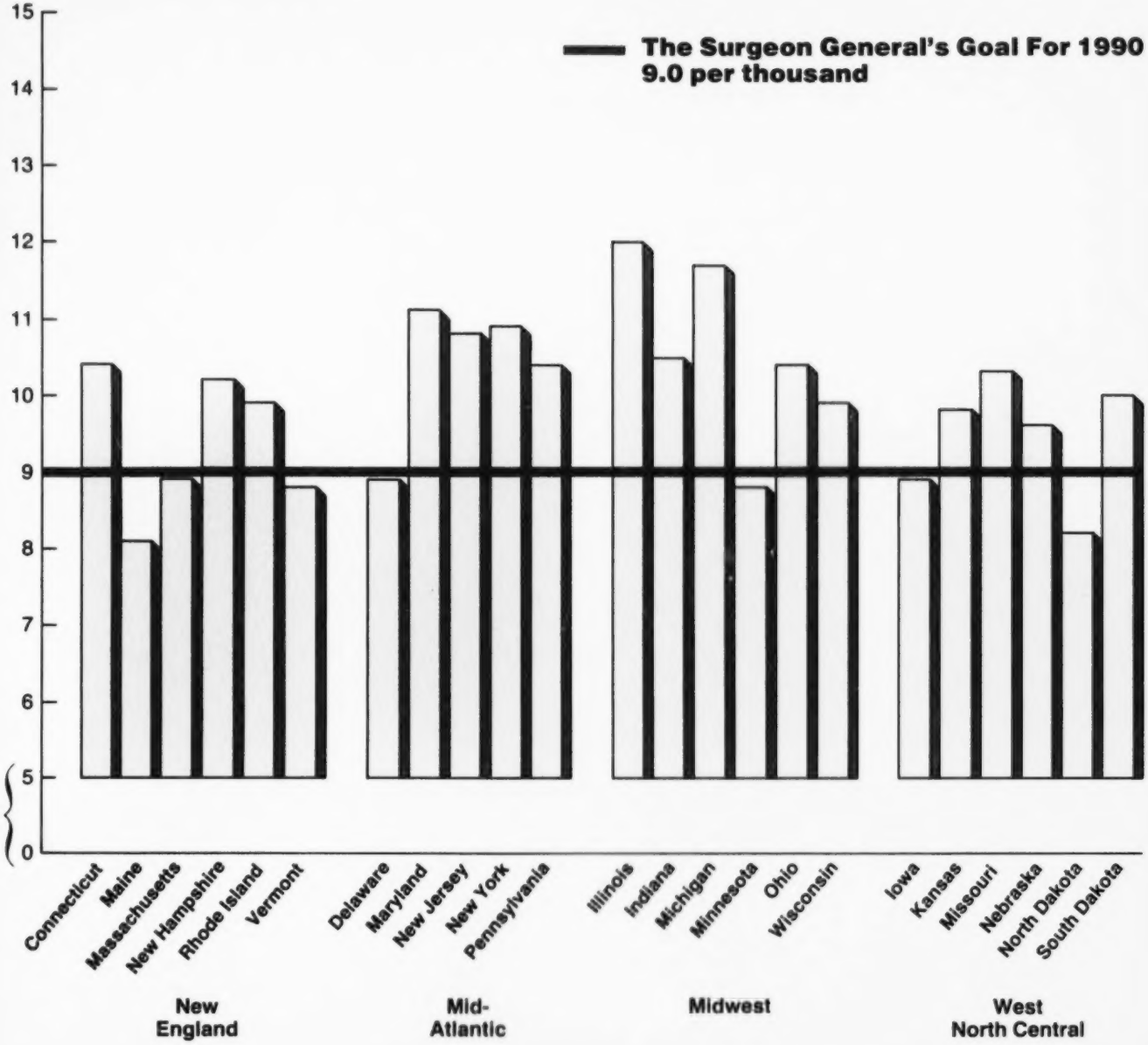
Region	State	Infant Mortality Rate 1986	Percent of Low-Birthweight Infants 1985	Percent of Women Not Receiving Prenatal Care in First Trimester 1983
Total United States		**10.4**	**6.8**	**23.8**
New England	Connecticut	10.3	6.4	14.3
	Maine	8.1	5.6	16.0
	Massachusetts	8.9	5.9	14.4
	New Hampshire	10.2	5.1	15.2
	Rhode Island	9.9	6.4	15.3
	Vermont	8.8	5.9	17.1
Mid-Atlantic	Delaware	8.9	7.2	23.4
	Maryland	11.1	7.7	21.5
	New Jersey	10.8	7.2	19.3
	New York	10.9	7.2	28.2
	Pennsylvania	10.4	6.7	21.0
Midwest	Illinois	12.0	7.2	22.2
	Indiana	10.5	6.3	22.8
	Michigan	11.7	7.0	18.8
	Minnesota	8.8	5.1	20.9
	Ohio	10.4	6.7	19.0
	Wisconsin	9.9	5.4	16.2
West North Central	Iowa	8.9	5.0	14.4
	Kansas	9.8	6.1	18.8
	Missouri	10.3	6.7	20.8
	Nebraska	9.6	5.4	19.4
	North Dakota	8.2	4.7	18.5
	South Dakota	10.0	5.1	27.9
East South Central	Alabama	13.1	7.9	26.8
	Kentucky	11.6	6.9	25.0
	Mississippi	14.4	8.8	25.4
	Tennessee	11.8	8.0	25.3
South Atlantic	Florida	10.8	7.4	31.8
	Georgia	13.4	8.4	24.8
	North Carolina	12.5	7.8	22.2
	South Carolina	14.7	8.6	33.5
	Virginia	12.3	7.2	19.4
	West Virginia	11.0	6.7	28.0

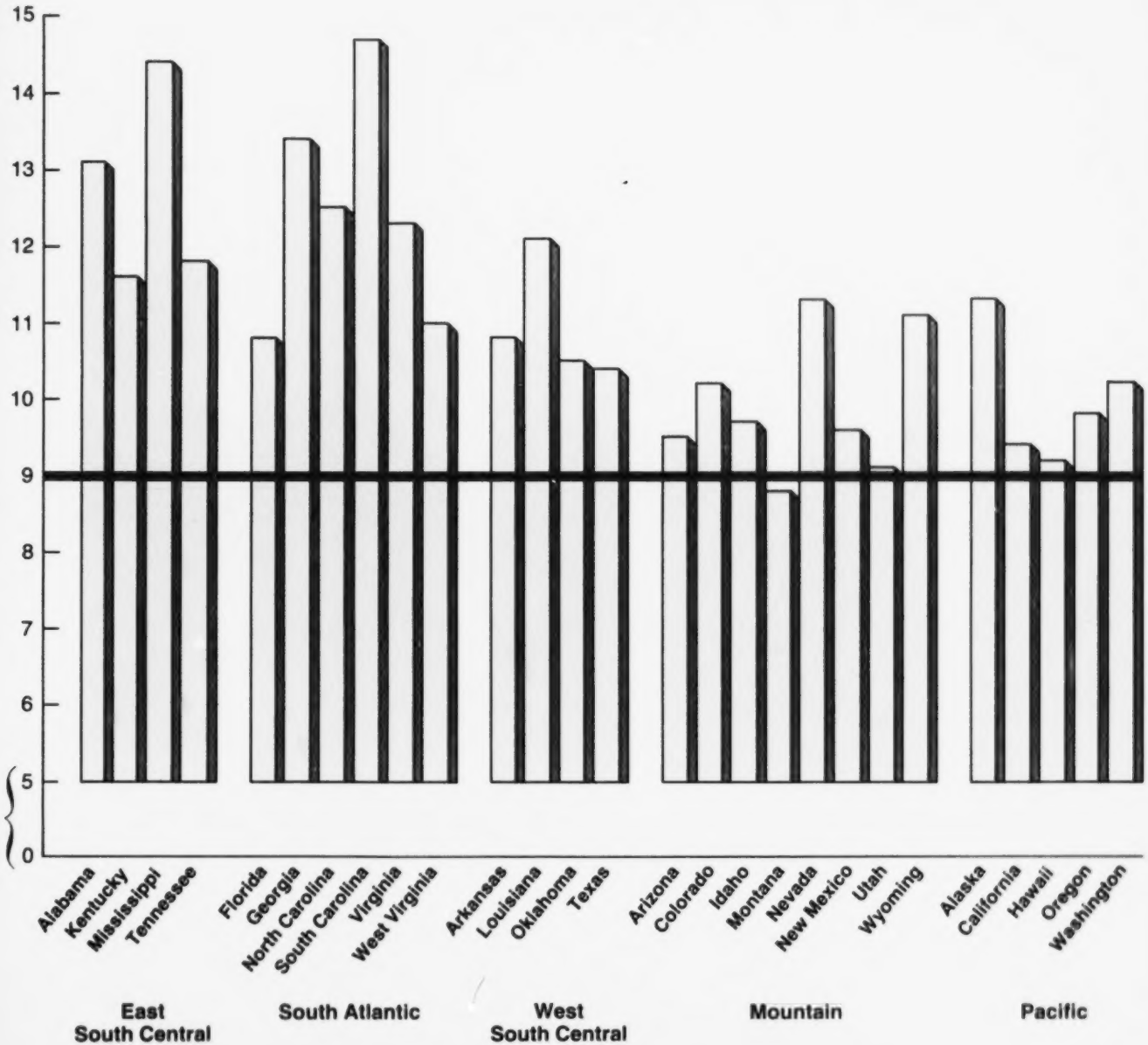
INFANT HEALTH (Cont'd)

Region	State	Infant Mortality Rate 1986	Percent of Low-Birthweight Infants 1985	Percent of Women Not Receiving Prenatal Care in First Trimester 1983
Total United States		**10.4**	**6.8**	**23.8**
West South Central	Arkansas	10.8	7.8	31.9
	Louisiana	12.1	8.6	21.7
	Oklahoma	10.5	6.7	32.6
	Texas	10.4	6.9	32.3
Mountain	Arizona	9.5	4.7	27.4
	Colorado	10.2	7.9	23.6
	Idaho	9.7	5.6	24.3
	Montana	8.8	5.6	20.8
	Nevada	11.3	7.0	25.9
	New Mexico	9.6	7.6	38.5
	Utah	9.1	5.6	17.8
	Wyoming	11.1	7.1	21.3
Pacific	Alaska	11.3	4.7	24.8
	California	9.4	7.8	22.9
	Hawaii	9.2	7.0	25.9
	Oregon	9.8	5.0	22.5
	Washington	10.2	5.2	22.4

Infant Mortality Rate

Per 1,000 Live Births

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YOUNG MOTHERS AND YOUNG CHILDREN

Region	State	Number of Births to Mothers Under Age 20 1985	Number of Mothers Under Age 20 Receiving AFDC 1985	Percent of Working Mothers With Children Under Age 6 1985
Total United States		**477,705**	**212,822**	**47**
New England	Connecticut	4,050	2,239	41
	Maine	1,980	1,128	45
	Massachusetts	6,971	5,116	42
	New Hampshire	1,277	150	50
	Rhode Island	1,414	1,332	45
	Vermont	785	395	48
Mid-Atlantic	Delaware	1,318	827	49
	Maryland	8,253	4,798	51
	New Jersey	10,323	6,255	39
	New York	25,993	15,254	41
	Pennsylvania	18,525	7,918	37
Midwest	Illinois	22,646	14,703	43
	Indiana	11,416	3,318	47
	Michigan	16,632	10,406	42
	Minnesota	5,086	3,053	50
	Ohio	21,372	12,763	42
	Wisconsin	7,497	5,980	49
West North Central	Iowa	3,837	2,144	49
	Kansas	4,522	1,492	48
	Missouri	10,388	4,757	51
	Nebraska	2,322	1,676	49
	North Dakota	914	287	47
	South Dakota	1,232	382	51
East South Central	Alabama	10,702	4,547	49
	Kentucky	9,298	3,584	49
	Mississippi	9,039	4,498	54
	Tennessee	11,417	4,724	51
South Atlantic	Florida	22,774	7,876	51
	Georgia	16,686	5,865	54
	North Carolina	14,322	3,753	58
	South Carolina	8,809	2,930	58
	Virginia	10,506	4,690	50
	West Virginia	4,117	2,177	32

YOUNG MOTHERS AND YOUNG CHILDREN (Cont'd)

Region	State	Number of Births to Mothers Under Age 20 1985	Number of Mothers Under Age 20 Receiving AFDC 1985	Percent of Working Mothers With Children Under Age 6 1985
Total United States		**477,705**	**212,822**	**47**
West South Central	Arkansas	6,756	1,766	51
	Louisiana	14,090	5,263	44
	Oklahoma	8,417	1,427	47
	Texas	47,029	9,966	48
Mountain	Arizona	8,156	1,809	45
	Colorado	5,726	1,544	46
	Idaho	1,844	464	43
	Montana	1,335	370	45
	Nevada	1,858	509	54
	New Mexico	4,295	1,048	43
	Utah	3,326	937	37
	Wyoming	1,083	205	42
Pacific	Alaska	1,112	478	47
	California	51,290	27,825	46
	Hawaii	1,796	620	52
	Oregon	4,185	1,912	43
	Washington	7,223	4,279	43

STATE AND FEDERAL SUPPORT PROGRAMS

Region	State	Combined AFDC and Food Stamp Benefits as a Percent of the Poverty Level 1986	Percent of WIC Financially Eligible Population Actually Served 1986	Percent of Cases in which a Collection on a Child Suport Obligation Was Made 1986
Total United States		**74**	**40.4**	**15.6**
New England	Connecticut	96	65.3	29.4
	Maine	78	40.6	24.5
	Massachusetts	87	41.5	39.5
	New Hampshire	78	49.4	20.7
	Rhode Island	93	50.1	11.5
	Vermont	95	76.5	24.9
Mid-Atlantic	Delaware	69	39.1	37.0
	Maryland	75	40.7	25.7
	New Jersey	79	37.9	23.7
	New York	95	40.8	26.9
	Pennsylvania	76	47.4	26.3
Midwest	Illinois	73	47.6	7.3
	Indiana	64	35.8	8.2
	Michigan	89	46.1	20.3
	Minnesota	91	48.7	27.9
	Ohio	69	56.9	12.1
	Wisconsin	92	48.3	29.8
West North Central	Iowa	76	42.0	21.4
	Kansas	79	39.2	11.0
	Missouri	66	34.5	13.2
	Nebraska	73	33.8	25.5
	North Dakota	75	40.4	17.3
	South Dakota	75	32.4	21.7
East South Central	Alabama	46	40.7	13.7
	Kentucky	56	38.1	7.1
	Mississippi	46	57.1	6.2
	Tennessee	51	39.0	11.2
South Atlantic	Florida	65	34.8	7.2
	Georgia	64	49.7	8.1
	North Carolina	64	43.2	14.4
	South Carolina	57	39.5	7.2
	Virginia	74	39.0	6.2
	West Virginia	63	42.7	5.3

STATE AND FEDERAL SUPPORT PROGRAMS (Cont'd)

Region	State	Combined AFDC and Food Stamp Benefits as a Percent of the Poverty Level 1986	Percent of WIC Financially Eligible Population Actually Served 1986	Percent of Cases in which a Collection on a Child Suport Obligation Was Made 1986
Total United States		**74**	**40.4**	**15.6**
West South Central	Arkansas	56	32.8	15.7
	Louisiana	55	41.1	11.7
	Oklahoma	69	36.0	3.4
	Texas	55	36.5	8.2
Mountain	Arizona	68	28.4	6.9
	Colorado	73	37.3	5.1
	Idaho	69	28.1	15.4
	Montana	74	38.6	6.3
	Nevada	67	53.2	26.3
	New Mexico	64	24.9	6.1
	Utah	76	31.1	21.6
	Wyoming	74	62.8	9.6
Pacific	Alaska	104	27.6	14.0
	California	99	31.1	16.3
	Hawaii	92	22.7	16.2
	Oregon	83	35.1	20.7
	Washington	89	31.5	19.5

INDICATORS OF LONG-TERM DEPENDENCY

Region	State	High School Dropout Rate 1985	Percent of Youth Ages 16 to 19 Unemployed 1986	Number of Juveniles in Custody Per 100,000 Juveniles in the Population 1985	Percent of Total Population Receiving Public Assistance 1985
Total United States		**25.4**	**19.0**	**185**	**6.2**
New England	Connecticut	19.6	14.7	74	4.8
	Maine	21.4	13.5	167	6.3
	Massachusetts	23.7	9.4	32	6.0
	New Hampshire	24.8	10.4	127	2.2
	Rhode Island	32.4	15.4	133	6.1
	Vermont	16.6	15.7	–	5.9
Mid-Atlantic	Delaware	30.1	14.6	264	5.3
	Maryland	22.3	14.6	263	5.4
	New Jersey	22.7	14.8	166	6.2
	New York	37.3	18.8	98	8.2
	Pennsylvania	22.8	18.2	76	6.2
Midwest	Illinois	26.0	19.9	126	7.5
	Indiana	23.6	19.6	193	3.8
	Michigan	28.1	22.2	170	9.3
	Minnesota	9.4	12.5	125	4.2
	Ohio	23.9	19.1	230	7.4
	Wisconsin	16.0	14.5	112	7.2
West North Central	Iowa	13.5	18.3	112	4.8
	Kansas	18.6	13.0	233	3.7
	Missouri	23.9	14.9	158	5.5
	Nebraska	13.1	15.5	140	3.5
	North Dakota	13.9	16.5	111	2.6
	South Dakota	14.9	10.6	222	3.4
East South Central	Alabama	37.0	21.1	133	7.1
	Kentucky	31.8	25.3	130	6.8
	Mississippi	38.2	26.4	114	10.2
	Tennessee	35.9	24.2	195	5.9
South Atlantic	Florida	38.8	17.7	189	4.1
	Georgia	37.4	20.6	161	6.7
	North Carolina	29.7	15.0	142	4.9
	South Carolina	37.6	20.9	175	6.3
	Virginia	24.3	21.3	218	4.1
	West Virginia	27.2	26.1	45	7.3

INDICATORS OF LONG-TERM DEPENDENCY (Cont'd)

Region	State	High School Dropout Rate 1985	Percent of Youth Ages 16 to 19 Unemployed 1986	Number of Juveniles in Custody Per 100,000 Juveniles in the Population 1985	Percent of Total Population Receiving Public Assistance 1985
Total United States		**25.4**	**19.0**	**185**	**6.2**
West South Central	Arkansas	24.3	28.7	93	5.8
	Louisiana	45.3	27.9	200	7.7
	Oklahoma	28.9	19.3	80	5.2
	Texas	36.8	20.0	125	4.0
Mountain	Arizona	35.5	13.3	244	3.4
	Colorado	27.8	16.7	156	3.6
	Idaho	23.3	14.7	87	2.6
	Montana	17.1	18.8	198	3.3
	Nevada	36.1	21.2	425	2.1
	New Mexico	28.1	22.5	275	5.4
	Utah	24.1	14.4	73	2.8
	Wyoming	25.7	20.1	231	2.2
Pacific	Alaska	32.9	21.9	314	3.8
	California	34.2	20.1	430	8.8
	Hawaii	26.2	19.8	123	6.0
	Oregon	27.3	18.2	222	3.6
	Washington	25.1	21.1	260	4.8

INTRODUCING THE CASE STUDIES

During the spring of 1987, NGA synthesized the results of a year-long effort of five gubernatorial task forces to analyze selected barriers to self-sufficiency, including teenage pregnancy and parenting, welfare dependency, dropping out of school, adult illiteracy, and substance abuse. The analysis culminated in the completion of individual task force reports each featuring agendas for state action to "Bring Down the Barriers." Though some of those agendas differed on the fine points, there was remarkable congruence around the steps that need to be taken to prevent these barriers, in the best instance, or to remove them after they have taken root.

The initial steps recommended by the task forces include: **Determine who is Affected** (by a problem); **Estimate the Costs of Inaction;** and **Profile, Target, and Inform.** These steps entail collecting data to estimate needs and characterize the at-risk population; assessing the current costs to the state and to political subdivisions in the state of *treating* the problem instead of preventing it; and disseminating profiles of the at-risk population and the cost estimates to legislators, community leaders, and the public in order to build support for action and target prevention on those most at risk.

The next broad steps generally were designated as **Mobilize, Plan, and Budget.** These steps call for creating a broad commitment to the new prevention initiative across state agencies; establishing interagency policy committees or cabinet clusters to establish the prevention policy and, ultimately, develop the initiative; creating opportunities and inducements for public/private collaboration; holding public hearings to enhance awareness of the at-risk populations' problems and to build support for solutions; developing measurable goals for helping the at-risk population and decreasing the incidence of their subsequent problems; and identifying a combination of private, local, state, and federal resources that can be targeted on the initiative.

The third step, put succinctly, is to **Act.** Activities include insuring implementation of the new program; maintaining broad public support for the new program; and undertaking a publicity campaign to make the program's availability known to prospective clients. Securing funding from the legislature and/or businesses and foundations is integral in this stage.

Finally, the agendas call for states to **Maintain Accountability.** This requires continued oversight of interagency collaboration; holding state and local agencies accountable for achieving the goals developed in the earlier step; and evaluating the program to assess its effectiveness and determine any need for refinement. Evaluation findings also serve as vital grist for securing renewed or expanded funding of prevention programs.

The following pages contain case studies that document five states' efforts to implement prevention strategies for children in their first sixty months of life. Based on interviews with state officials and others involved from the beginning, the case studies chronicle the steps these states went through to assess needs and to develop, implement, and evaluate quite diverse prevention programs for children zero to five years of age. One program focuses on children's deaths, a second on preschool education, a third on parenting education, a fourth on children's health, and the fifth addresses a broad array of risks to young children. Three of the

programs were implemented in states with moderately rural populations, one in the far northeast, two in the south. Two were carried out in largely urban states; one in the northeast, the other in the midwest. Four of the programs owe their development to strong leadership from the Governor while the fifth credits the initiative's creation and leadership to a private businessman. Two represent public/private partnerships.

Despite this diversity, there are close parallels between the implementation strategies employed in each of the states as well as parallels with the action steps recommended in the Governors' "Barriers" initiative. In the case study section, "Genesis of Interest in Prevention Programs," interview respondents discuss the process by which state staff determined who is affected, estimated the cost of inaction, profiled and targeted the at-risk population, and began information dissemination to the public. In "Laying the Groundwork," there is a description of the steps required to generate public support, mobilize interagency collaboration, plan and establish goals, and budget. In "Getting Off the Ground," the states' procedures for securing funding (from the legislature and elsewhere) are detailed along with information on outreach campaigns for prospective clients and program implementation. The "Follow Up and Oversight" activities mirror those described as accountability in the "Barriers" task force reports. At the heart of this step is evaluation.

In summary, there is an emerging consensus about the strategies necessary to implement prevention programs. This consensus is buttressed by the tested and proven models exhibited in the case studies which follow.

CASE STUDIES

ILLINOIS' OUNCE OF PREVENTION FUND

An innovative public/private partnership has been working in Illinois since 1982 to counter the adverse effects of a poverty ridden environment on children, and, ultimately, on society. Known as the Ounce of Prevention Fund, this program is designed to prevent the cumulative family problems that can result in infant mortality, child abuse and neglect, delayed development, and repeated cycles of teenage pregnancy and parenthood.

The public half of the partnership is readily apparent: The State of Illinois. The private side of the Ounce of Prevention Fund has been its Co-founder and current President, Irving Harris.

Genesis of Interest in Prevention Programs

The origins of the Ounce of Prevention Fund can be traced to the persistence and inventiveness of Harris, a Chicago businessman and philanthropist. He first began learning and reflecting about the cycle of poverty and its effect on children in the late 1950s when he was with an educational publishing company. That firm provided materials for school counselors, and one of the main issues was the prevention of high school dropouts. In 1964, he was impressed by *Crisis in Black and White* by Charles Silberman. The book cautioned that the dropout problem cannot be solved until policy makers recognize that it does not start in high school, junior high school, first grade, or even kindergarten. The dropout problem originates when the child leaves the cradle and begins an exploration of his environment leading to his further intellectual development. Where that environment is bland or worse, destructive, development is arrested. Solving this problem will require the reversal of the effects of a starved environment, Silberman said.

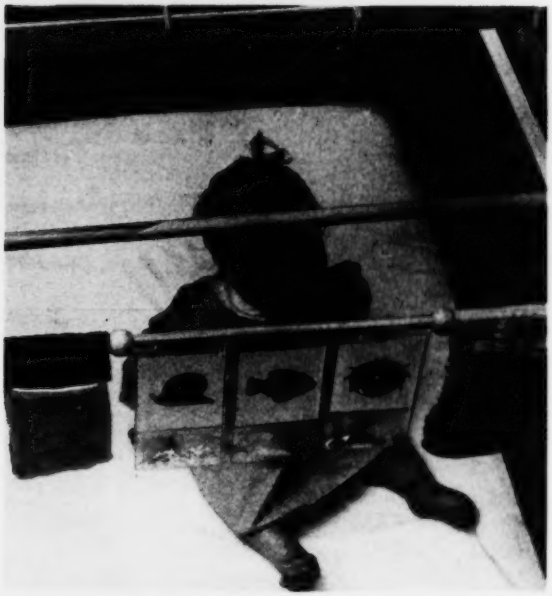
Harris became interested generally in the area of early childhood education and, in particular, in the Head Start Program. This program is designed to prevent school failure. Results of the program show that the children can be grouped, for the most part, into three categories: one-third who have good home environments and probably would make it without a Head Start Program; another third who benefit immensely from the program; and the final third for whom even Head Start is too late, as they have been too badly damaged and delayed before they enter the program.

In 1975, Harris was approached by a former Head Start administrator with an opportunity to reach these most at-risk children. He agreed to help fund a non-profit social service organization to work with families with children under age three. The first Family Focus drop-in center was opened in 1976, and served five times the projected number of parents and children its first year. A second center, focusing on teen mothers and their children, opened in 1980, and was located near a high school. These centers were successful in lowering the incidence of low-birthweight babies and encouraging young mothers to wait before having a second baby. The programs also now include infant day care centers.

While Family Focus met with increasing success, there was not a corresponding rise in the amount of funds available to support the centers. Foundation funds had been acquired but they were for a fixed period of time. It seemed these funds would run out just when the need was greatest. Harris and the others involved in the program sought a steadier stream of funding.

The next source of funding they chose to pursue was the corporate sector. Harris thought that if a similar family-oriented center were suggested near the site of a corporation's facility, corporate self-interest would warrant an investment. In order to test this notion and to set an example, Harris decided to try the experiment in a low-income neighborhood where his company, the Pittway Corporation, operated a manufacturing plant. Many of the company's employees lived in this area, and it

was in the interest of the company and the community to fund a drop-in center near the plant. The plan called for a three-year experiment, with Pittway providing a substantial amount of the initial funds while trying to convince other area employers to become financial supporters.



Laying the Groundwork

As plans progressed during the next year, it was suggested to Harris that the center apply to Illinois' Department of Children and Family Services for a portion of the funds. After all, this new center would be a model prevention program and should be of interest to the state as a way to reduce child abuse and neglect. The budget was estimated at $100,000, and the center asked the state to fund $25,000 of this.

Harris received an unexpected response from the Director of the Department of Children and Family Services. He told Harris that it was high time the agency invest a significant level of funds for programs that would broadly test the concept of primary prevention. Rather than invest $25,000 in the new drop-in center, he volunteered to commit $400,000 in state funds if the Pittway Corporation would match the amount. His goal was to establish six experimental sites around the state that would more widely test the concept of prevention for young children and adolescents.

The commitment of such a large amount of state funds probably would not have been possible without a similar commitment from someone such as Irving Harris. This is especially true given the radical nature of the proposed experiment. With the financial and philosophical alliance of a large private corporation backing him up, though, the director felt that the Department of Children and Family Services could leverage its $400,000 on a matching grant basis and have less difficulty with the legislature in obtaining an appropriation in succeeding years. He felt the confidence expressed by the Pittway Corporation would undoubtedly have some influence with members of the legislature.

Harris, meanwhile, took this proposal back to the board of the Pittway Corporation Charitable Foundation in mid-1981; this was by far the largest grant it had ever considered. He pointed out that the long-term success of the corporation would depend upon the economic and social health of the community, not only near the manufacturing plant but also in all of the places where Pittway products are sold. Similarly, the issues relating to early childhood development are of concern to the nation as a whole and therefore Pittway's effort would have national significance. The board also was swayed by the matching funds the state had offered, especially since the director had promised that the entire $800,000 annual budget for the project would be covered in the second and third years solely by the state. This meant that Pittway's $400,000 actually would be leveraged against a total of $2.0 million in state funds over three years. When the Pittway board agreed in 1981 to the joint initiative with the State of Illinois, a public/private partnership known as the Ounce of Prevention Fund was born.

Getting Off the Ground

In January 1982, a public announcement detailed the creation of the Ounce of Prevention Fund. Proposals for innovative prevention programs were sought statewide. Out of a total of 115 concept papers, six were chosen for a three-year funding period. A major selection criterion was the existence of a strong community base of support from which a successful program could be built. In these six programs, provider training was carried out in churches, social service agencies, schools, and other local organizations.

The scope of the Ounce of Prevention Fund programs broadened in 1983. In that year the Governor launched a series of coordinated measures to combat what he characterized as "the epidemic of teenage pregnancy." The "Parents Too Soon" initiative combines the efforts of several departments of state government to address the needs of pregnant and parenting teens. The Ounce of Prevention fund was chosen as the administrative agent for the segment of Parents Too Soon assigned to the Department of Children and Family Services. In addition to helping the Ounce of Prevention Fund expand the variety of services it could deliver, state resources jumped considerably to $2.8 million in the second year of the program. The Pittway Corporation, having already met its financial obligation for the first year, still contributed another $250,000 to the effort.

These funds allowed the program to grow from six sites in the first year to twenty-eight by the end of the second year. Expansion of the Parents Too Soon and other state-supported programs increased the state's contribution to $4.5 million in the third year of the program.

Another aspect of the dual nature of the Ounce of Prevention Fund is its ability to flexibly use funds provided by its private sector donors. Unlike state funds which must be earmarked for a specific purpose far in advance, the more flexible private funds can be used by the Ounce of Prevention Fund whenever needed. One of its programs, in fact, got its start thanks to this feature.

In 1984, an innovative proposal came out of the Chicago public school system to establish a program of family life education courses in four middle schools. The proposal was turned down by the state. However, with its flexible private funds, the Ounce of Prevention Fund was able to provide the resources to initiate the program.

Now in its fourth year, the program has targeted seventh and eighth graders judged to be at high risk of early pregnancy. So far, out of the more than sixty students who have participated, not one has become pregnant. The program is now state funded and there are plans to expand it to additional middle schools.

Controversial Clinics. The power and prestige of the Governor has served the Ounce of Prevention Fund well. Besides advocating increased support for prevention programs for young children and adolescents, he also stood by the Ounce when it initiated one of its more controversial components.

In an effort to prevent the first birth to low-income teenagers, the Ounce of Prevention Fund joined with a local hospital to establish school-based health clinics at two Chicago high schools, Orr and DuSable. The latter, with a population of 1,000 girls and 1,000 boys, had seen 300 babies born to teen mothers in 1984 alone. The state agreed to fund half the cost of the clinics, and private funds were raised to cover the balance. The DuSable clinic opened in April 1985.

Three months after the clinic at DuSable opened, a controversy threatened its existence. Although students needed written permission to use the clinic, some took issue with the clinic's practice of dispensing contraceptives to students even though specific parental permission was required. A public letter to the Governor from a minister in the black community stirred media

and other attention, bringing protestors and local and national camera crews to DuSable. The resulting furor led to the withdrawal of support by three members of the school board and a delay in the opening of the second clinic.

However, support at the local and state levels helped keep the program alive. A survey of parents, students, and the community near Orr High School indicated that 85 percent were supportive of the clinic. Supporters of the additional clinic also pointed to the fact that neither the principal of DuSable nor the Superintendent of Education received a single negative call from a parent regarding the DuSable clinic. The Governor and the Director of the Department of Public Aid also made known their support for the second clinic.

Since then, the Governor has stated his conviction that comprehensive school-based clinics can be effective in reducing teenage pregnancy and in providing prenatal care, as well as comprehensive health care to all students. The state has appropriated the funds to operate two more such clinics. Meanwhile, in 1987, the Parents Too Soon program received one of ten $100,000 prizes awarded by the Ford Foundation and the Kennedy School of Government at Harvard University for imaginative solutions to public problems.

Head Start on Head Start. The Ounce of Prevention Fund's latest objective is the prevention of developmental delays in children. Their most recent effort draws on what has been learned from other programs it has sponsored across the state. The goal of the new initiative is to prevent the wide-scale failure of low-income children in school by insuring they arrive prepared both mentally and physically for the challenges of kingergarten.

Known as the Beethoven Project because it serves an area in a Chicago housing project near Beethoven Elementary School, the new program enlists expectant mothers whose children will make up the school's kindergarten class of 1993. The mothers will receive comprehensive prenatal and infant care to get their children off to the right start. Services will be provided throughout the first sixty months of the children's lives.

Funding for the first three years of the program is being shared equally by Irving Harris, personally, and the U.S. Department of Health and Human Services, with the state funding day care for the children. Harris hopes to see the state play a bigger role and already has pursued the Departments of Children and Family Services, Mental Health, Public Aid, and Public Health about helping out with various aspects of the Beethoven Project. He also has approached the Governor with a proposal for using new federal funds available to states for handicapped infants and toddlers to replicate the program in two or three other sites.

Follow Up and Oversight

The programs of the Ounce of Prevention Fund so far have met with success and acceptance. Each site is being evaluated to provide feedback for refining individual programs and for strengthening services in other Ounce programs. There also is a research department within the Ounce that examines basic issues in primary prevention. Studies on topics such as day care, adoption, and sexual abuse will be used in future program development.

Irving Harris sees a growing interest nationwide in primary prevention programs for at-risk young children. The Speaker of the Illinois Assembly recently set up a Select Committee on Children. The Governor, too, is interested in testing out new prevention programs. "The Governor," says Harris, "believes that prevention is not only wise, but that it's also good politics. So do I."

MAINE'S CHILDREN'S DEATHS INITIATIVE

Many of the most pressing problems facing a state's young population are not easily identified or described. The complexity of issues often makes it difficult for state government to take action since no single "problem" can be cited as a reason for a state-backed initiative. Occasionally, however, the needs of children capture the imagination of the public, creating a consensus upon which these needs can be identified and addressed.

Genesis of Interest in Prevention Programs

In 1981, a series of deaths of young children over a short period of time sparked a renewed interest in the well-being of children in Maine. Four homicides of poor children had occurred at the hands of relatives. These incidents were front-page news, and the resulting attention prompted those in state government to act.

The Governor requested that a study be done to assemble the facts necessary to identify the causes of children's deaths in the state. The study was undertaken by the Department of Human Services using existing staff and research capabilities. The technical staff gathering and synthesizing individual pieces of information were coordinated by executive-level staff within the deparltment. Those staff were to bring an overview of the entire issue to the supervision of the data collection; they also regularly briefed the Governor as the study progressed.

Released in late 1982, the study's most alarming finding was that children from poor families died at a rate three times higher than that of children from higher income brackets; infants aged birth to one year were at greatest risk. Diseases and illnesses claimed the highest number of children, and poor children also were three times more likely to die from these causes. This was occurring even though most were eligible to receive health services under Medicaid.

Laying the Groundwork

Now that the department had acquired the knowledge, the Governor sought to create awareness. Using the institutional capacity of state government for public education, the Governor directed that the results be disseminated to as wide an audience as possible. The Governor joined in a press conference to announce the conclusions of the study and expose the public to the information. Over 4,000 copies of the final report were distributed. This helped land the information on the front and editorial pages of the state's newspapers and on its television stations.

One audience singled out for special attention was comprised of a variety of people and professionals who had in common the capability to shape opinions and promote the changes needed to address successfully the issue of unnecessary deaths of children. The report was sent to legislators, judges, district attorneys, law enforcement officials, hospitals, schools, editors, pediatricians, churches, and social service and child welfare personnel. This was the first step toward creating a receptive climate for the coming state government initiatives.

After the results of the study had been disseminated, the Governor instructed the human services department to convene a statewide conference to develop a consensus on a state response to issues raised in the study. Held in June 1983, the conference drew over 400 people, featured a kick-off speech by the Governor, and brought more media attention to the issue. A committee was created from those attending the conference to make specific recommendations to the department. The membership of the committee was broad-based, including legislators, child advocates, social workers, pediatricians, nurses, educators, and others. Careful attention was paid to eliciting the cooperation and involvement of local officials. The executive branch assigned the necessary support staff.

The goal of the executive branch was to use the committee to convert the original knowledge, awareness, and concern into a specific action agenda. By empowering those who would be working daily with any changes or new techniques relative to children's well-being, the Governor gained not only expert advice but also a constituency who now were signed onto his agenda. The use of expert advice also gave the entire initiative an air of pragmatism rather than ideology. By calling on people of differing professional backgrounds, he showed that advancing the prevention of child mortality is less the responsibility of a specific discipline than one requiring cooperation and commitment from the many quarters seeking a better environment for the state's children. Finally, he specifically charged the committee to focus on what could be done right in the future, rather than dwelling on what had been done wrong in the past.

Getting Off the Ground

After the committee had studied the various problems, it issued a series of recommendations for state action. In November 1983, the Governor reconvened the original statewide conference participants. The purpose of this second conference was to consider the recommendations of the committee and to maintain momentum on the issue. The conference was held just six weeks prior to the next session of the state legislature. Many of the recommendations presented at this conference became the Governor's explicit executive agenda for children's well-being in the State of Maine. They came to serve as a public reference point for the upcoming debates in the legislature and in the press.

The package, known as the "Governor's Agenda for Children," contained new laws along with a supplemental budget appropriation. Including additional federal funds, a total of $5.0 million would be available for early intervention programs. Purposes for which these resources would be used were:

- increases in the monthly AFDC benefit;
- emergency assistance to those families most in need;
- the initiation of Medicaid benefits to two-parent families and first-time pregnant women;
- the extension of Medicaid benefits for a period after a family leaves the AFDC rolls;
- the creation of child care programs for AFDC families;

- rate increases to medical professionals participating in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program;
- increases in payments to family providers participating in the foster care program;
- initiation of a state program for the loan of infant and toddler auto safety seats;
- training of child care providers in accident prevention, first aid, and disease detection; and
- the purchase of time on commercial television stations to publicize the availability of the new benefits.

A child health policy committee would be created. The heads of the several responsible state agencies would comprise its membership.

Owing to the advance publicity and the Governor's active interest, expectations for approval were high when the legislation was introduced. Since many of the actions proposed were prevention-oriented and centered on entire families, they would be supported by conservatives and liberals alike. The months of attention given to early childhood deaths had created a situation which called unquestionably for positive state action. Many lawmakers, when asked in the weeks prior to the beginning of the legislative session what priorities would receive their attention, cited the need to deal with the questions raised by the children's deaths study. No one, after all, could be against preventing the death of children.

Every member of the legislature was contacted by phone or letter and informed of the initiative. Many received similar contacts from constituents. Special attention was paid to the legislative leadership, the chairs of the appropriations and human resources committees, and the Women's Legislative Caucus. Members of both parties were signed on as co-sponsors of the various bills.

The Governor formally presented the package to the legislature in his 1984 "State of the State" message, calling it part of an "unfinished agenda" designed to address the problems of the state's abused and neglected children. The Governor's budget was used as the primary vehicle for pushing the agenda forward. There also were several individual bills that sought statutory changes such as the seat belt requirement.

Thorough preparation by the executive branch, backed up by strong community support statewide, helped the package win approval by the legislature with relative ease. The package was sold as important, effective, and affordable. No one change was so dramatic as to cause an uproar by itself. Since no single change would be enough to cause significant improvements for at-risk children, it was perceived as essential to the effort's success that the entire package be enacted.

Those testifying on the bill's behalf included relevant executive branch officials, such as department commissioners and division directors, members of the study committee, and private citizens. An additional boost was given the package by the testimony of outside child welfare professionals, who were brought in because they could provide the perspective of those not beholden to state government.

Several factors helped keep opposition to a minimum. First, the compelling nature of the issue and the visceral response it evoked could not be countered easily. Second, the emotional side was complemented well by the careful collection and compilation of the facts necessary to identify the problem and point to its solution. Finally, line staff and professionals ultimately responsible for implementation conceived many agenda ideas. This guaranteed their support.

Follow Up and Oversight

Implementation of the individual items of the package began later in 1984. The additional services were promoted through frequent press releases and contact with physicians, day care providers, and state caseworkers. In 1986, the

state allocated $100,000—$75,000 from a federal grant—to launch an advertising campaign to attract more young pregnant women into doctors' offices and clinics for prenatal care. The funds were used to buy evening time on the state's commercial television stations to reach as much of the target audience as possible. Babies whose mothers receive no prenatal care for the first three months run an increased risk of disability and death. The avoidance of one birth defect saves the state $50,000 annually in the cost of institutionalization.

Since the authorization of this effort, the steps taken have gained even wider acceptance. Detailed monitoring of various indicators of children's well-being is conducted by the appropriate departments and the results then given to the executive and legislative committees charged with oversight. The necessary appropriations for components of the original bill are now built into the budget of the Department of Human Services each year. This creates the advantage of having an existing base from which to fund and even extend the initiative.

The initiative to prevent deaths among children in Maine has seen early success. Measured against the figures of the original study of children's deaths, the rate of children dying of all causes has been decreased by 11 percent—saving 206 children—with much of this reduction attributed to the positive impact of the Governor's children's agenda.

"America's children are powerless and in need of powerful friends."

–*America's Children,* A 1983 Report to the National Governors' Association

Genesis of Interest in Prevention Programs

Missouri's priority commitment to early childhood education, and parenting education as a vehicle for its accomplishment, dates back to 1972. The Department of Education issued a position paper laying out the research on the efficacy of supporting rather than supplanting parents in their role as the principal teachers of their preschool children. This theme continued to be championed into 1975, when the department sponsored its first statewide Conference for Decision Makers on early childhood education and parenting education. Participants included decision makers from the Departments of Health, Education, Social Services (including the Division of Family Services), Mental Health, and Corrections. Presenters laid out the research findings on the salutary effects of parenting education on early childhood development and later performance in school, and on the damaging long-term effects to children of poor parenting. In attendance at this conference was the Governor, who subsequently selected early childhood and parenting education as one of five topics to be addressed at his 1976 Governor's Conference on Education.

Laying the Groundwork

During the 1977 legislative session, legislators who had served on the Governor's Conference Committee on Early Childhood/ Parenting Education introduced a bill calling for state funding of screening and follow-up services for children three to five years of age. "The sponsors knew, at the time, that there was no hope of passage," reported the state official interviewed for this study. "It was too late in the session to consider a new initiative. They just wanted to establish awareness of the problems surrounding the treatment and remediation of children in their later years, and the improved chances for their healthy development with prevention" [through the education of parents with young children], she said.

Having established the precedent in 1977, the sponsors submitted a second legislative proposal in 1978. Though it passed the House this time, it was defeated in the more conservative Senate.

Getting Off the Ground

The Department of Education again convened a statewide Conference for Decision Makers in 1981 to consider the importance of providing support to parents of children even younger than three years of age. The Governor, who had been elected to a second term after four years out of office, was an active participant. Two developments emerged from that conference. The first was the original concept for a Parents as Teachers program. The second was the Department of Education's initiation of a train the trainers program for teachers of Chapter 1 of the Education Consolidation and Improvement Act (ECIA) and special education programs for three- and four-year-olds, as well as their parents. Using the research on prevention presented at the conference, department staff designed a Parents as Teachers Program for children birth to age three.

With funds from the state's Chapter 2 ECIA allocation, the Danforth Foundation, and four local school districts (but still no special appropriation from the legislature), the pilot program began in 1981. Four school districts were selected on the basis of competitive proposals, although substantial consideration also was given to their combined representativeness of the state. Among these four, a total of 380 parents expecting their first child between December 1981 and September 1982 were recruited, using two exclusionary criteria: the mother had to be at least sixteen years old and at least one adult in the family had to be English-speaking.

First implemented in the 1981/1982 school year and open to parents of all income levels, the Parents as Teachers (PAT) program offered the following parent services:

- assistance in fostering the child's language, cognitive, social, and motor development;
- periodic screening of the child's hearing, visual, motor, and language development;
- monthly private home visits by trained parent educators; and
- monthly group meetings for parents with similarly aged children held at "Parent Resource Centers" located in the schools.

During the home visits advice was provided on what to expect at each phase of a child's development; how to choose toys that stimulate curiosity and creativity; how to foster social development; and how to discipline without punishing.

In 1982, what was to become one of the most valuable components of the PAT program was undertaken with the appointment of Missouri business and government leaders to a blue-ribbon panel, the Commissioner's Committee on Parents. The committee's primary mission was to promote parent involvement in their children's education and publicize the Parents as Teachers program to the general public and the legislature. This mission, though, was expanded in later years.

During 1983, the Governor brought together high-level officials of the principal state agencies serving young children—social services, public health, mental health, education, and corrections. He asked them for estimates of the savings that could accrue to them from a statewide PAT program, and for statements of support to the legislature. For example, the health department estimated the number of children it lost track of after immunizations were administered and showed how the PAT program could be instrumental in reestablishing contact with these families for the purpose of regular health screenings. Similarly, the corrections department estimated the number of persons in prison who had highly troubled early childhood experiences in their families.

In 1984, the Missouri legislature passed the Early Childhood Development Act, an expanded version of the bill first introduced in 1977, authorizing state funds for developmental screening and educational services to parents of children birth through four years of age. Although it always had been intended that Parents as Teachers services would be available to parents and to school districts on a voluntary basis, a group of rural legislators took the largely unprecedented step of amending the bill to make the services mandatory for school districts. They felt, it is reported, that failure to mandate the program would see some of their districts eschewing the state funds for the program.

During the remainder of 1984, staff in the Department of Education and the Commissioner's Committee on Parents as Teachers "got ready" for the legislature to appropriate funds for implementation. The committee raised money from corporations and foundations for conducting outreach and publicity campaigns with parents, and for publicizing the progress of the four pilot PAT districts as well as the research supporting the efficacy of parental involvement in their children's early education.

Enactment was followed in 1985 with the legislature's appropriation of $2.8 million. This was the amount deemed necessary to serve 10 percent of the parents with children under four years of age, 17,725 families. Preparation for statewide implementation of PAT began in June of that year. It was undertaken with the full support of a new Governor, who had been sold on the program by the outgoing Governor. Programs were in place by January 1986. The pace of implementation had been given a boost with the October 1985 release of results from an independent evaluation of the four pilot Parents as Teachers projects. At age three, project children were significantly further advanced than comparison group children in language, intellectual, and social development. Traditional characteristics of "risk," e.g., parents' age, educational achievement, income, and single-parent status, bore no correlation with project children's achievement. Participation in the project positively affected parents' perceptions of themselves and their school district. These findings played an important role in helping to promote and stimulate "client" interest in the statewide program. They also lent valuable credibility to the pilot study staff who were used as trainers for the statewide staff of parent educators.

Each school district selects the prospective parent educators to receive training. Though they need not have a degree or certificate in early childhood education, they must have some experience working with young children and their parents.

The Commissioner's Committee on Parents as Teachers proved invaluable during implementation. As an example, an executive of a marketing firm took responsibility for developing an audio-visual presentation and a marketing plan for use by school districts. It should be noted that to date the legislature's appropriation does not cover the costs of materials development or training. The department absorbs these costs, using Chapter 2 and other funds. Training of parent educators is conducted in cooperation with the state university system, and trainees receive two hours of college credit for the price of one credit hour.

Follow Up and Oversight

Comprehensive follow up and oversight of parent educators is conducted through a network of support groups and through bi-monthly, regional, one-day in-service training classes. A statewide meeting of parent educators is held every March and a newsletter is circulated three times a year to share new ideas

on Parents as Teachers service delivery. Advanced training is offered each summer.

For the second year of PAT's operation, the legislature voted to increase the appropriation to $5.7 million, thus insuring that services could be provided to 20 percent of the state's families. In 1987, funding for PAT services increased to $11.4 million to allow the program to reach 30 percent of the families and to offer developmental screening and parent education through age four. State staff note, however, that some districts, with significant infusion of local funds, are serving in excess of 50 percent of their schools' families.

Representatives from social services, public health, mental health, and corrections serve on each district's PAT Advisory Committee, and are therefore in a position to refer families to the program. Courts mandate program participation for parents coming before them in child abuse and neglect cases. Noteworthy in the legislation is a provision that unused funds from any districts which underserve the targeted percentage of families be reprogrammed to those which overserve.

Two follow-up evaluations are underway. In the first (referred to as the second wave of the pilot site evaluation) thirty-two school districts representing metropolitan, suburban, Ozark, and migrant communities across the state have been selected for a longitudinal evaluation of PAT. Each district received a quota of participating parents with children under seven months of age to enroll in the study, which together will number 3,000 families. The parents and children will be followed for three years. By this time the sample will be large enough to analyze the impact of the program on subsamples and learn how the program variably impacts, and needs to be refined for, subgroups of families.

In the second study, PAT children and a comparison group of children from the original four pilot districts, who now have begun kindergarten, will be followed and evaluated through sixth grade. The longitudinal study will track their academic achievement and language, cognitive, social, and motor development.

Partial funding for both of these studies is being provided by the Missouri Department of Education and the Ford Foundation. State staff are quick to point out that evaluation data about the effectiveness of Parents as Teachers certainly help in persuading the legislature to continue (and increase) funding for the program. The best advocates have proven to be the parents and grandparents of children enrolled in the program. Further, the statewide marketing plan developed by the Commissioner's Committee, calls for each school district to persuade its legislator to serve on the district's Advisory Comittee. Experience has shown that this technique has turned opponents into vocal advocates for the program. Finally, national publicity accorded to PAT lends support to its advocates. Professionals from twenty-six states have been trained as parent educators or trainers. Twelve of these states have implemented Parents as Teachers programs and fourteen others are in the initiation stage.

Finally, an independent assessment of PAT's effectiveness resulted in the program receiving in 1987 the prestigious Innovations in State and Local Government Award from the Ford Foundation and John F. Kennedy School of Government at Harvard University. PAT was the only public school program to receive one of the ten $100,000 awards.

Genesis of Interest in Prevention Programs

In 1985, the Governor of New Jersey directed his Office of Policy and Planning to identify and develop proposals to deal with the state's most serious health problems. Due to its high infant death rate and poor child health statistics, the Governor personally identified the reduction of infant mortality and improvement of child and maternal health care as New Jersey's highest priorities. The statistics speak for themselves. In 1985, the state had an infant mortality rate of 10.8 deaths per 1,000 live births, compared with the national average of 10.4 deaths and the Surgeon General's goal for 1990 of 9.0 deaths. The non-white infant mortality rate was reported at 18.7 per 1,000 live births. The 1980 child health statistics indicated that inpatient admissions for children ages one to four were a high 186 per 1,000. It also was reported that 21 percent of all births in New Jersey were to women living at or below the federal poverty level.

Laying the Groundwork

In his January 1986 "State of the State" message, the Governor announced a new initiative to expand maternal and child health services. He directed his Office of Policy and Planning to begin designing and planning a program to expand services to pregnant women and children who were at or below the federal poverty level. Consistent with the gubernatorial initiative, the legislature passed a bill in March 1986 appropriating $2.7 million for the 1987 state fiscal year to improve medical services to low-income mothers and children. The subsequent enactment of the Supplemental Omnibus Budget Reconciliation Act (SOBRA) by Congress in January 1987 had a profound impact on New Jersey's plan to improve services. SOBRA permitted the state to extend

Medicaid eligibility to pregnant mothers and children who were at or below the federal poverty level. In effect, it meant the state's dollar commitment could be doubled. The state planners altered their thinking to consider the most effective, long-lasting use of the SOBRA options.

In the Governor's 1987 "State of the State" message he officially announced the development of a new statewide program, HealthStart. The program would be aimed at improving the accessibility and scope of maternal and child health services available in New Jersey to all Medicaid-eligible pregnant women and children under the age of two. Under the program, the package of services available to low-income women and children would include comprehensive maternity care to Medicaid-eligible pregnant women and comprehensive pediatric care to Medicaid-eligible children. Maternity care services would be provided including health support services such as nutrition assessment and social-psychological assessment as well as all those medical services recommended by the American College of Obstetrics and Gynecology. The pediatric care services would include preventive child health visits, all necessary immunizations, and an array of provider care services in the event that a child becomes ill during the first two years of life. At the Governor's direction, this Medicaid program would be planned and implemented jointly by New Jersey's Departments of Health and Human Services.

The Governor's staff fostered cooperation by meeting with key agency heads to reinforce the common goal of reducing infant mortality and improving the health status of young children, and to reaffirm the inherent long-term cost savings for both departments. Additionally, there was encouragement to draft a Letter of Agreement, establishing their joint purpose and goals.

In February 1987, the joint inter-departmental planning group reviewed and compiled demographic, cost, and cost savings projections for legislative staff. One month later, just prior to appropriation hearings for the state's fiscal year 1988, the legislative staff and legislators were presented with a complete plan including goals, methods, and cost estimates. This comprehensive presentation of the facts mitigated any significant legislative opposition.

In March, the legislature passed a bill to appropriate $4.5 million to support the services to be made available under HealthStart. Due to the state's participation in SOBRA, however, there actually would be $9.0 million available for HealthStart's administration and services beginning July 1987.

Getting Off the Ground

Once the state's commitment to HealthStart had been made, it was the Governor who pulled together the two principal agencies, the Department of Human Services and the Department of Health, to plan and implement this joint initiative. With HealthStart officially signed into law on May 4, 1987, program staff were identified in the two departments. Assisting state staff were Technical Advisory Panels (TAPS) established to define the content of the HealthStart program. The TAPS were made up of 200 persons throughout the state, divided into three areas: provider outreach; provider services; and data evaluation. Groups who were represented on the TAPS included health care professionals in the state, New Jersey's Medical Society, and the state chapters of the American Academy of Pediatrics, the University of Medicine and Dentistry, the

American College of Obstetricians and Gynecologists, the Academy of Family Practitioners, and the College of Certified Midwives. Other important participants who contributed to the process included providers who already were offering services under the Maternal and Child Health Block Grant and individuals experienced with the Medicaid recipient population.

In addition to state funds, two sources of private funding were secured in order to facilitate the linkage of HealthStart providers and hire outreach workers in the community. Prior to New Jersey's participation in SOBRA, the Commissioner of Health had met with the Robert Wood Johnson Foundation to discuss how that organization might assist in New Jersey's efforts to improve maternal and child health statistics. The commissioner was looking for funding which the HealthStart providers might apply for independently; the resources would be used to help link them together to form cohesive regional perinatal systems. The foundation agreed with the need and awarded grants of $6.0 million over four years to help five regional consortia in New Jersey facilitate provider cooperation and plan coordination.

Another private foundation grant was secured from the Ford Foundation. This is a two-year, $300,000 state grant to make funds available to HealthStart providers for purchasing or hiring outreach workers at the community level. The foundation awarded the grant in August 1987 which will allow the Department of Health to award the grants by April 1988.

With a starting date of February 1988, HealthStart now is preparing to launch a major publicity campaign. The staff presently are seeking additional funds for this purpose. They are hopeful that a portion of the state-appropriated $4.5 million can be made available for publicity and community outreach.

HealthStart staff have had their dress rehearsal for the four major statewide outreach meetings which are scheduled to take place before February. These meetings are designed to inform potential providers about HealthStart, including its programmatic and administrative requirements. As part of this provider recruitment campaign, a major mailing was sent to all hospitals, prenatal clinics, OB/GYN clinics, family practitioners, and pediatricians. The mailing provided a fact sheet about HealthStart. Program applications then will be sent to these same groups.

If the Department of Health is able to receive additional funds, it is planning to provide a toll-free telephone number to answer questions regarding the location of local HealthStart providers and the kinds of services available in the vicinity. It also is planning on designing a HealthStart poster for advertisements on buses and in other public places. Finally, it plans to include HealthStart notices with the monthly checks sent to AFDC recipients.

Follow Up and Oversight

Each HealthStart provider must be a Medicaid provider and hold a certificate issued by the Department of Health verifying the provider's ability to deliver the comprehensive HealthStart services. Provider certificates will be reviewed for renewal every eighteen months. HealthStart officials will make site visits every eighteen months to monitor the quality of HealthStart providers' performance and to use the data reported for quality assurance.

Evaluation of HealthStart will be a joint effort of the Departments of Health and Human Services. The health department will design, direct, and coordinate the overall evaluation. Both departments will be responsible for collecting and analyzing data. The first purpose of the evaluation will be to determine: the state's success at getting HealthStart services to the high-risk population; whether providers are delivering the services which they agreed to provide; what barriers continue to impede the

delivery of HealthStart services; and whether the program has been effective for the population utilizing its services. A second purpose of the evaluation is to collect information that will reinforce aspects of the program which have been successful and that can be used to correct problems which have stood in the way of the program's goals. The information generated from this evaluation and the documentation of all aspects of program implementation will be submitted annually to the Governor and the New Jersey State Legislature.

The evaluation process includes three components. The monitoring component will review and assess the program's processes, strengths, and weaknesses. Monitoring information will be used to identify and address program operational problems.

The second evaluation component involves a quality assurance function which provides direct training, review with feedback, and retraining of personnel. Once program needs are identified, related quality assurance activities will be the responsibility of the various state, county, and local authorities with the Department of Health serving to coordinate these activities.

The third evaluation component will be a long-range focus on the extent to which HealthStart has improved access to services and health outcomes in the state. The data to be collected will include the infant mortality rate, the percentage of low-birthweight infants, the timeliness of prenatal care, and the rehospitalization rate for children participating in the program.

Genesis of Interest in Prevention Programs

In early 1983, soon after both the Governor and State Superintendent of Education had been reelected, both gentlemen independently convened a task force to study the state of public education in South Carolina. The Governor's task force looked across the board at kindergarten through graduate school, the arts, museums, and research, while the Superintendent's task force focused on grades K-12. Both groups reached remarkably similar conclusions: "that progress could be shown but that there was a long way to go." Among the indicators (using 1979 data) that led to these conclusions were:

- test scores below the national average in almost every grade and in almost every subject;
- scores from a reading-readiness, one-on-one developmental test for children entering first grade which revealed 40 percent "not ready";

- 250,000 of 600,000 children scoring below acceptable standards on a basic skills test; and
- a large number of low-income children throughout the state.

According to a former official from the Governor's office interviewed for this study, these findings spurred both men into efforts to determine "what steps could be taken by the state to make a quantum leap forward in the quality and product of its public education system."

Laying the Groundwork

Their efforts subsequently merged in the formation of two blue-ribbon panels which included business leaders, former governors, a former state superintendent, legislators, and prominent education and civic leaders. The panels were to examine the current system and make recommendations for reform whereby a significant difference could be shown in five to ten years. Simultaneously, a series of local public forums were initiated around the state. Held in the evenings, the forums featured no more than fifty minutes of speakers' presentations followed by small group discussions of problems and recommended solutions. By day, a group of fifteen prominent citizens would visit all the surrounding school districts in the area hosting the forum to observe the educational environment, speak to chambers of commerce and at PTA meetings, and participate on television and radio talk shows. Then these prominent citizens would make speeches at the regular meetings of their Kiwanis Club, Rotary Club, and other organizations about the need for major educational improvements. Summaries of advice garnered during the public forums were transmitted back to all forum participants, as well as to the blue-ribbon panels. In all, 13,000 citizens participated in forums across the state, and another 50,000 to 75,000 were touched through the visits and the Speakers' Bureau.

By the fall of 1983, when this intense and very public effort was, with considerable press attention, reaching a peak, the now famous U.S. Department of Education's *A Nation at Risk* was being discussed widely. Along with other major national reports, the publication decried the sorry state of public education in America. The timing was auspicious, and the reports became a formidable ally in the Governor's and Superintendent's cause.

In the fall of 1983, the blue-ribbon panels recommended to the Governor and Superintendent a sixty-one point plan, the South Carolina Education Improvement Act. Central to the plan was a call to raise the educational standards for all children in the state's public education system, preceded by offering opportunities for the children to meet those standards. Thus was born an early childhood development program for at-risk four-year-olds, though this genesis relied for ammunition on the results of an earlier pilot project with 2,500 four-year-olds. Also other early childhood and remedial basic skills programs were initiated to give at-risk children a fair chance to meet the higher standards.

Packaging the early childhood piece of the program for marketing to prospective advocacy groups and to the legislature was a careful process, since there frequently exists in states resistance to preschool education programs in general, and to their delivery by the public school system in particular. With considerable foresight, the Governor had formed in 1980 an Interagency Early Childhood Development and Education Council comprised of representatives from the social services, health, and education departments as well as private, non-profit service providers. The council was to review the status and needs of preschool children in the state, develop a five-year plan, and initiate a variety of pilot projects. This was propitious, as arguments soon surfaced among die-hard supporters of early childhood development programs about the advisability of running preschool programs in the public schools. Some

argued they should be run by the Department of Social Services, others by Head Start. In addition, there were other issues including the length of the program day and the program's integration with existing child care arrangements.

After several months of intense disagreement, an accord was reached that featured the following points of compromise:

- School districts were given the option of contracting out their preschool development program for at-risk four-year-olds. This meant that where a school district was found wanting in its delivery of services to preschool children, local advocates could presumably pressure that district into contracting out its four-year-old program to a social service agency or private non-profit provider.
- Some pressed for a full-day rather than a half-day program. As the state couldn't afford a full-day program, the language in the proposed act was changed to mandate "at least a half-day of early child development program," thus encouraging some local districts to fund the rest of the day.
- Similarly, there was concern about links to parents' child care arrangements for their four-year-olds enrolled in a half-day preschool program. So the education department was urged to adopt a more flexible transportation schedule for four-year-olds than that applied to the rest of the students. For example, buses can pick children up at home, but then drop them off at a nearby day care center for the rest of the day, if on the route.

In addition, agreement was reached to continue oversight by the Interagency Early Childhood Development and Education Council. It would give advice to the Governor on progress and problems in the new preschool program, and annually update its five-year plan.

The legislation and first year funding ultimately was passed in June 1984. The initial appropriation of $2.0 million for the half-day preschool child development component was scheduled to increase to $13,000,000 after full phase-in. It is notable that during debate, only two groups lobbied against the whole educational reform package: half of the textile manufacturers in the state and an association of retail merchants. Though they rallied around an argument that the reforms were too much, too fast, it is probable that the real galvanizing force was a one-cent sales tax increase proposed to fund the package. Equally notable, on the other hand, is the fact that every major education association in the state endorsed the package and fought for it, as did the three largest chambers of commerce who lent the services of their chief lobbyists to the campaign.

Getting Off the Ground

Once enacted, the Department of Education developed regulations and guidelines to assure that the programs were developmentally sound and appropriately staffed. A six-year phase-in schedule was necessary to give sufficient time to some districts which had no prior experience with preschool programs; time was needed to find space, to recruit and train teachers, and to accommodate the schedule of funding. During the 1984/1985 school year, 2,000 four-year-olds were enrolled in the half-day programs. The schools with the highest number of children with low readiness scores were first in the queue to receive their allotment of funds. By the 1987/1988 school year, 8,500 at-risk four-year-olds were enrolled in at least a half-day preschool program, representing almost 20 percent of all four-year-olds in the state.

Additionally, several thousand other at-risk four-year-old children are enrolled in federally financed programs. Add to this the 2,500 enrolled in a previously implemented pilot preschool program, and the state has covered approximately 70 percent of all at-risk four-year-olds within its borders.

The current appropriation for South Carolina's half-day preschool child development program is $8.0 million and is expected to reach almost $10 million for the 1988/1989 school year. At full implementation, the annual goal is to serve 15,000 four-year-olds who are at risk of school failure. The state provides direct funding for the developmental program (i.e., teachers, teachers' aides, materials) while the school district covers, for the most part, the administrative, building, and overhead costs. Transportation is provided by the state.

Follow Up and Oversight

Each school district selected to receive state funds must mount a public awareness campaign using local churches, social service agencies, health department referrals, and publicity materials sent home from school with older siblings.

Staff development, training, and technical assistance is conducted through a network of colleges and universities across the state. Winthrop College has been selected as the state's Center of Excellence in Early Childhood Education to assist in this endeavor. Each school district is required to use the cognitively oriented preschool curriculum developed by the High Scope Educational Research Foundation in Ypsilanti, Michigan. This curriculum is heavily interactive and has no teacher lectures. The structure for preschool programs is typified by the integration of four parts: the teaching objectives, a well-defined classroom arrangement of children's interest centers, a predictable daily routine, and units or themes of study.

The objectives try to answer the child's natural curiosity and appetite for learning. The pupil/teacher ratio is low, at one to ten, with one professional teacher and a teaching assistant for every 20 children. Another key to the model, besides the developmental curriculum and the low pupil/teacher ratio, is the requirement for parent involvement. A minimum of two parent conferences and two home visits by the teacher (the first prior to the opening of school) are required during the school year, though many districts exceed this minimum. Some districts, where lack of classroom space or transportation prevents children from attending the center-based programs, utilize the outreach component of the child development model to work with parents in the home.

During implementation, Department of Education staff conducted an evaluation of implementation, results, and the appropriateness of curriculum usage. Children in those centers fully implementing the program showed significant gains. The two centers which received a zero rating showed no student gains. As a result of these findings the department is strengthening its technical assistance and monitoring functions, and the evaluation of effectiveness and degree of implementation will continue.

With $200,000 in state funds, the department is supporting a five-year longitudinal evaluation of the program, using four-year-olds on the waiting list as a control group. First grade readiness assessments of their language, cognitive, social, and motor development will be administered, followed by basic skills tests during the first, second, and third grades. Data on the placement of program and control group children in remedial courses also will be analyzed. Early evaluation findings indicate less placement in remedial programs for children who participated in the four-year-old child development programs.

To date, South Carolina points with pride to results from the first years of operation of its comprehensive reforms. Preliminary results which have some connection to the early childhood initiatives are as follows:

- **Readiness** - The number of first graders who are considered ready for doing typical first grade work has climbed from 60 percent in 1979 to 75 percent in 1986.
- **Reading** - The number of first graders meeting reading standards has increased by 14 percent, and third graders meeting reading standards in 1987 showed a 20 percent increase over 1981 scores.
- **Math** - These scores for first graders showed a 16 percent rise from 1981 to 1987, and third graders showed a 22 percent increase.
- **Achievement Gains in Later Grades** - Early evaluation findings indicate that achievement gains in early grades carry forward into later grades when coupled with the effects of instructional improvements in those grades.

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